making referrals to appropriate providers and monitoring the services received to make sure they are coordinated and meeting the beneficiaries' needs. Case managers can also help beneficiaries in areas such as obtaining a job, housing, or legal assistance. When services are coordinated through a case manager, the chances of successful treatment are improved.

For those who cannot be treated while living in their own homes, this bill will make several residential treatment alternatives available. These alternatives include residential detoxification centers, crisis residential programs, therapeutic family or group treatment homes, and residential centers for substance abuse. Clinicians will no longer be limited to sending their patients to inpatient hospitals. Treatment can be provided in the specialized setting best suited to addressing the person's specific problem.

Right now in psychiatric hospitals, benefits may be paid for 190 days in a person's lifetime. This limit was originally established primarily in order to contain Federal costs. In fact, CBO estimates that under modern treatment methods, only about 1.6 percent of Medicare enrollees hospitalized for mental disorders or substance abuse used more than 190 days of service over a 5-year period.

Under the provisions of this bill, beneficiaries who need inpatient hospitalization can be admitted to the type of hospital that can best provide treatment for his or her needs. Inpatient hospitalization would be covered for up to 60 days per year. The average length of hospital stay for mental illness in 1995 for all populations was 11.5 days. Adolescents averaged 12.2 days; 14.6 for children; 16.6 days for older adolescents; 8.6 days for the aged and disabled; 9.9 days for adults. A stay of 30 days or fewer is found in 93.5 percent of the cases. The 60-day limit, therefore, would adequately cover inpatient hospitalization for the vast majority of Medicare beneficiaries, while still providing some modest cost containment. Restructuring the benefit in this manner will level the playing field for psychiatric and general hospitals.

The bill I am introducing today is an important step toward providing comprehensive coverage for mental health. Further leveling the health care coverage playing field to include mental illness and timely treatment in appropriate settings will lessen health care costs in the long run. These provisions will also lessen the social costs of crime, welfare, and lost productivity to society. This bill will assure that the mental health needs of all Americans are no longer ignored. I urge my colleagues to join me in support of this bill.

A summary of the bill follows:

TITLE I PROVISIONS

The bill prohibits health plans from imposing treatment limitations or financial requirements on coverage of mental illness if similar limitations or requirements are not imposed on coverage of services for other conditions.

The bill amends the tax code to impose a tax equal to 25 percent of the health plan's premiums if health plans do not comply. The tax applies only to those plans who are willfully negligent.

TITLE II PROVISIONS

The bill permits benefits to be paid for 60 days per year for inpatient hospital services furnished primarily for the diagnosis or treatment of mental illness or substance abuse. The benefit is the same in both psychiatric and general hospitals.

The following ''intensive residential services'' are covered for up to 120 days per year: residential detoxification centers; crisis residential or mental illness treatment programs; therapeutic family or group treatment home; and residential centers for substance abuse.

Additional days to complete treatment in an intensive residential setting may be used from inpatient hospital days, as long as 15 days are retained for inpatient hospitalization. The cost of providing the additional days of service, however, could not exceed the actuarial value of days of inpatient services.

A facility must be legally authorized under State law to provide intensive residential services or be accredited by an accreditation organization approved by the Secretary in consultation with the State.

A facility must meet other requirements the Secretary may impose to assure quality of services.

Services must be furnished in accordance with standards established by the Secretary for management of the services. Inpatient hospitalization and intensive residential services would be subject to the same deductibles and copayment as inpatient hospital services for physical disorders.

PART B PROVISIONS

Outpatient psychotherapy for children and the initial 5 outpatient visits for treatment of mental illness or substance abuse of an individual over age 18 have a 20% copayment. Subsequent therapy for adults would remain subject to the 50% copayment.

The following intensive community-based services are available for 90 days per year with a 20% copayment (except as noted below): partial hospitalization; psychiatric rehabilitation; day treatment for substance abuse; day treatment under age 19; in home services; case management; and ambulatory detoxification.

Case management would be available with no copayment and for unlimited duration for ''an adult with serious mental illness, a child with a serious emotional disturbance, or an adult or child with a serious substance abuse disorder (as determined in accordance with criteria established by the Secretary).''

Day treatment for children under age 19 would be available for up to 180 days per year.

Additional days of service to complete treatment can be used from intensive residential days. The cost of providing the additional days of service, however, could not exceed the actuarial value of days of intensive residential services.

A non-physician mental health or substance abuse professional is permitted to supervise the individualized plan of treatment to the extent permitted under State law. A physician remains responsible for the establishment and periodic review of the plan of treatment.

Any program furnishing these services (whether facility-based or freestanding) must be legally authorized under State law or accredited by an accreditation organization approved by the Secretary in consultation with the State. They must meet standards established by the Secretary for the management of such services.

SALUTE TO ORVENE S. CARPENTER

HON. ELTON GALLEGLY

OF CALIFORNIA

IN THE HOUSE OF REPRESENTATIVES

Wednesday, February 5, 1997

Mr. GALLEGLY. Mr. Speaker, I would like to salute Orvene S. Carpenter for many years of outstanding service to his community on the occasion of his retirement.

Orvene Carpenter began his public service over 50 years ago in the city of Port Hueneme when he was appointed postal clerk. He was later elected to the city council and served for 30 years, becoming the longest tenured councilmember in the history of the city of Port Hueneme. He was elected mayor in 1990.

I have had the great pleasure of working with Mr. Carpenter for many years. During that time he has been responsible for numerous accomplishments and outstanding progress in the city of Port Hueneme. He will be missed greatly in both the government and civic arenas in which he was so active.

His innumerable contributions will serve as a legacy to his years of dedication. I want to congratulate him and wish him the very best in his retirement.

INTRODUCTION OF LEGISLATION TO ALLOW PENALTY-FREE WITHDRAWALS FROM CERTAIN RETIREMENT PLANS DURING PERIODS OF UNEMPLOYMENT

HON. JIM McDERMOTT

OF WASHINGTON

IN THE HOUSE OF REPRESENTATIVES

Wednesday, February 5, 1997

Mr. McDERMOTT. Mr. Speaker, today I am introducing legislation that would allow people to receive penalty-free withdrawals of funds from certain retirement plans during long periods of unemployment. I am pleased that Representatives CHARLES RANGEL, ROBERT MATSUI, JOHN LEWIS, RONALD DELLUMS, ESTEBAN TORRES, ELEANOR HOLMES NORTON, ROBERT RUSH, MAURICE HINCHEY, VIC FAZIO, ZOE LOFGREN, EVA CLAYTON, and CHARLES CANADY have joined me as original cosponsors of this legislation.

This legislation would allow penalty-free withdrawals from individual retirement accounts [IRA's] and qualified retirement plans—401(k) and 403(b))—if the taxpayer has received unemployment compensation for 12 weeks under State or Federal law. Under the legislation, the distribution of funds would have to be made within 1 year of the date of unemployment.

Under current law, when a taxpayer withdraws money from an IRA or a qualified retirement plan before age 59½, he or she is forced to pay an additional 10 percent tax on the amount withdrawn. This additional tax is intended to recapture at least a portion of the tax deferral benefits of these plans. This tax is in addition to regular income taxes the taxpayer must pay as the funds are included in the taxpayer's income. The early-withdrawal tax also serves as a deterrent against using the money in those accounts for nonretirement purposes.

The vetoed Balanced Budget Act of 1995 includes a provision which is the same as this legislation with respect to withdrawals from IRA's. This provision recognizes that when an individual or family is faced with long periods of unemployment, they may have no other choice but to draw upon these funds to meet their everyday living expenses. During this financially stressful time, an additional 10 percent tax for early withdrawal is unfair and only serves to make the family's financial situation